New Hampshire

Topical Immunomodulators Medications

First Health Services Corporation
A Coventry Health Care Company

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ _

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Desired Length of Therapy:_____

Section II: Clinical History:

1. Please provide the diagnosis/condition this medication is being prescribed to treat: _____
   _____
   _____
2. What is the patient's age? _____
3. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
   If yes, please describe treatment failure, contraindication, or intolerance and provide date:
   _____
   _____
   _____
   _____
   _____
4. Has the patient been treated with a topical immunomodulator in the past? ☐ Yes ☐ No
   If yes, please provide drug name and duration of therapy: _____
   _____
   _____
   _____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet

_____
_____
_____

Section III: Prescriber Information:

Print Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider